dividing skin and platysma. This incision should be a little short of three inches. The operator should then lay aside his knife, ligature the external jugular vein in two places, and divide it in the direction of the original incision. The deep cervical fascia should now be divided, and the edges of the wound gently separated, when the posterior belly of the omo-hyoid muscle will be exposed for its entire length. The edges of the wound should now be retracted, and the superior retractor should carry with it the omo-hyoideus; and when this has been done, the white cords of the plexus, with the artery inferior and internal to them, will be observed to occupy the bottom of the wound. The knife should now be laid aside, unless it is necessary to dissect a lymphatic gland out of the way, and the vessel separated from the lowest cord of the plexus with a director, and ligatured in the usual manner. Tying the external jugular vein is not insisted upon, provided it can be easily drawn aside, but generally a ligature would expedite matters, and any branches of this vein which cross the line of incision should, if divided, be treated in the same manner.

"What are the advantages claimed for the operation recommended? Why have the stereotyped guides to the artery—viz., edge of anterior scalenus, and tubercle on first rib—not been mentioned? What special advantages has the operation described over that commonly practised—*i.e.*, by incision along or near the upper margin of the clavicle?

"The advantages claimed for the operation are—1. That the incision is parallel to the normal course of the artery. 2. That the true guide to the vessel—posterior belly of omo-hyoid—is exposed by incision recommended for its entire length. 3. That the edges of incision admit of easy retraction, and, in this way, of easy access to the vessel. 4. That the risk of venous hemorrhage obscuring the final steps of the operation is lessened.

"My answer to the second question I have asked is very simple. To feel the edge of the scalenus anticus in a bleeding wound is next to, if not quite, an impossibility, and it does not follow that the tubercle on the first rib is always so well developed as to permit of recognition by the sense of touch; and, independently of both these surgical signposts, it has always appeared to me that a far more reliable guide is to be found in the omo-hyoideus.

"Regarding the third question—What special advantages are claimed for this operation over that commonly practised?—it may be stated, I think, that, if an incision is made in a line with the clavicle, it is obvious that, when carried deeper, it will not meet with the omo-hyoideus or true guide unless at its outer angle; whereas the incision recommended is parallel to that muscle throughout its entire length. Secondly, in the wound resulting from the ordinarily used incision, retraction can only be made in an upward direction, as the clavicle prevents retraction downwards; whereas, with the incision now recommended, retraction can be made in both directions. Thirdly, in the incision recommended there is no risk of dividing the transverse cervical vessels; whereas, when the incision along the clavicle is used, they are often cut, and, when it so happens, very troublesome bleeding obscures the further steps of the operation."

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47. *Traumatic Aneurism from Gunshot Wound.*—Dr. JOESSEL (*Gaz. Méd. de Strasbourg*, 1871, No. 2), as Director of a Military Hospital in Hagenau, had an opportunity of observing the infrequency of traumatic aneurism after gunshot wounds. In a patient with a gunshot wound at the inner side of the left thigh, somewhat near its middle, on the 8th day subsequent to the receipt of the wound, an arterial hemorrhage occurred, which was controlled by ligation of the femoral artery immediately above the course of the ball in the muscles of the thigh; on the next day there was developed at the inner face of the thigh a pulsating tumour, which, notwithstanding the application of direct compression and compression of the artery at the groin, at the end of eight days had acquired the size of a child's head. Its pulsations were evident to the eye, while by auscultation the aneurismal murmur was detected, but which disappeared when compression was made upon the artery above. Dr. J. concluded that the aneurism had been the result of a wounding of the arteria femoris profunda, and that a cure could be effected by ligating the femoral artery behind the origin of the vessels supplying it with blood. The artery was tied close under

Poupart's ligament, and at the end of six weeks the cure was complete.—*Centralblatt f. d. Med. Wissenschaften*, June, 1871, No. 25. D. F. C.

48. *Excision of the Scapula.*—Mr. CHARLES STEELE communicated to the Surgical Section of the British Medical Association the following case of this:—

C. B., aged 8, was admitted on April 14 into the Bristol Royal Infimary, on account of a large swelling upon the right scapula, which had been forming only six weeks, and had enlarged very rapidly during the last fortnight. The tumour covered the whole surface of the scapula except the inferior angle, and encroached over the upper border towards the clavicle; it was firmly adherent to the scapula, most prominent over the spine, and had a highly elastic and, in parts, fluctuating feeling. The child had fallen off in flesh slightly, and looked rather delicate. Mr. Steele made an exploratory incision, and removed a minute portion of the substance, which on microscopic examination showed large, almost square, cells filled with secondary cells. Extirpation of the scapula was decided upon; and, on the 18th, after making a free incision down to the bone through the tumour, to confirm diagnosis, Mr. Steele made a free elliptical incision from the upper border to the inferior angle, carefully surrounding the first incision, so as to avoid infiltration. He then slipped the inferior angle of the scapula from under the latissimus dorsi, divided the muscles attached to the posterior and anterior borders, freed the subscapularis muscle from its surroundings, divided all connections of the clavicle and humerus close to those bones, and, by very delicate dissection, cleared the projections of the tumour from their close proximity to the subclavian vessels, etc. The suprascapular, posterior scapular, and subscapular arteries, and one muscular branch, were secured. The forearm was supported across the chest, and a compress of wool applied over the excavated cavity. The tumour had evidently sprung from the bone; it covered its dorsum, infiltrated its tissue, formed a large firm projection on the venter, and had stretched the supraspinatus, infraspinatus, and subscapularis muscles as a capsule inclosing it. Recovery steadily progressed till the seventh week; the wound was then nearly healed, the child ate well, had gained in flesh, was able to be up all day and go into the garden, and looked well. Two nodules of encephaloid now recurred, and were removed entire, the intercostal muscles being cleaned in doing so. Ten days afterwards, a fresh nodule formed near the spine; and the granulating surface of the wound became so infiltrated that all hope of further removal had to be abandoned. It was some satisfaction to notice that all recurrence of disease was in the lower part and towards the spine. Mr. Steele remarked that this case showed clearly two points: first, that the operation was well borne by the system, and recovered from; and, secondly, that even before cicatrization was complete, a surprising amount of movement existed in the arm. The hand and forearm could be freely used, and the arm drawn well forwards, also extended from the side, and even drawn backwards by the latissimus dorsi muscle. This showed that, had the disease not returned, a very useful limb would have resulted.—*British Medical Journal*, August 26, 1871.

49. *Primary Excision of the Elbow-joint.*—C. F. MAUNDER, Surgeon to London Hospital, states (*Lancet*, May 20, 1871) that all surgeons are familiar with the operation of excision in cases of disease of the elbow-joint, but he believes that primary excision of the ends of the bone forming this articulation in cases of compound fracture opening the joint is not familiar to all surgeons as a substitute for amputation. During the ten years he has been on the surgical staff of the London Hospital, he has performed excision at least eight times. "An injury in this region of the upper extremity must," he says, "be very severe indeed to induce me to amputate the limb. The worst condition would probably be that in which a large extent of soft parts had either been carried away or been so damaged as to be beyond repair, and even then I would cut away an equivalent in bone so as to adapt the length of limb to remaining sound structures. Every attempt should be made to save a healthy hand; and it should also be borne in mind that the injury is situated at the upper and not the lower part of the forearm—a very important fact as regards the future